**INLAND EMPIRE HEALTH PLAN**

# REQUEST FOR UM CRITERIA LOG

IPA Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Log for Year: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| Date Requested | Date Sent | Sent via:  F = fax  EM = email  GM =ground mail | Name of the Requesting Practitioner or Member | Member Name and IEHP ID # | Line of Business (MC, DSNP, CCA) | Criteria Requested (i.e. InterQual-MRI Brain) | Reason for Request |
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